TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-16-3525-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for the services rendered because we have submitted the appropriate paperwork needed for review along with our authorization #544414-01."

Amount in Dispute: $756.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the 3/7/2016 date of service for a left knee brace through Universal DME has been reprocessed and has been paid."

Response submitted by: AIG, P.O. Box 25794, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2016	L1832	$756.93	$141.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. Texas Labor Code 408.0284 sets out network provisions for durable medical equipment.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Workers' compensation jurisdictional fee schedule adjustment
   - 3 – The provider billed for the monthly rental or lease of equipment that was previously purchased
   - 2 – The charge for the procedure exceeds the amount indicated in the fee schedule

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code 134.203 (b) states in pertinent part,

   For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   28 Texas Labor Code §134.203(d) states in pertinent parts,

   The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   Review of the DMEPOS fee schedule finds the following;

   - The Medicare 2016 1st Quarter, Texas Fee Schedule amount found at www.dmepdac.com/dmecsapp/do/feesearch, for submitted code is:

     L1832 - $541.94 x 125% = $677.43

2. The maximum allowable for the services in dispute is $677.43. Per notice from requestor dated August 29, "There was a payment issued in the amount of $536.08 made on 08/25/16 leaving a $144.07 balance." The remaining balance of $141.35 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $141.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $141.35 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.